APPLICATION FOR FAMILY AND YOUTH REPRESENTATIVE STATE-LEVEL COUNCILS, WORKGROUPS, COMMITTEES ETC.

NAME: _____ DATE: _____

ADDRESS: _____

PHONE: _____ CELL: _____

E-MAIL ADDRESS: _____

PAST EXPERIENCE ON LOCAL, REGIONAL OR STATE COUNCILS, WORKGROUPS, COMMITTEES, BOARDS ETC. ALSO INCLUDE ADVOCATING FOR SELF OR OTHERS.

_____

_____

WHY DO YOU WANT TO PARTICIPATE ON A STATE-LEVEL COMMITTEE?

_____

_____

WHICH OF THE FOLLOWING GROUPS WOULD YOU REPRESENT?

PARENT ___ YOUTH (AGE 16-24) ___ CAREGIVER ___ KINSHIP ___ GRANDPARENT ___
FOSTER/TREATMENT FAMILY HOME _____ OTHER: _____

WHAT ARE YOUR AREAS OF EXPERTISE OR SPECIAL INTEREST? (check all that apply)

Department of Mental Health: CPS _____ MR/DD _____ ADA _____
Individualized/Person Centered Planning ____ Mental Health/Physical Health _____
Public Awareness/Anti-stigma _____ Easy Early Access __ School-based Mental Health _____
Evidence Based Practices ____ Early Childhood/Prevention ___ Transition Age ___ Juvenile Justice ____ Consumer/Family/Youth Leadership _____ Public Speaking ___ Evaluation ____
Family Support Provider __ Family run organizations ____ Children's Division _____ Youth Services _____ Special Education _____ Other: _____

PLEASE PROVIDE 2 REFERENCES:

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

Do you have transportation that allows you to travel outside your local area? Yes or No

Please send application to: Department of Mental Health
Office of Transformation
1706 E. Elm St.
Jefferson City, MO 65101
E-mail to: transformation@dmh.mo.gov
Fax to: 573-526-3072